

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CALIFORNIA DID NOT ALWAYS ENSURE
THAT ALLEGATIONS AND REFERRALS OF
ABUSE AND NEGLECT OF CHILDREN
ELIGIBLE FOR TITLE IV-E FOSTER CARE
PAYMENTS WERE PROPERLY RECORDED,
INVESTIGATED, AND RESOLVED**

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Office of Inspector General

<https://oig.hhs.gov>

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Report in Brief

Date: September 2017
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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

Congress has expressed concerns about the safety and well-being of children in foster care. These issues were highlighted in a media report that provided several examples of children who died while in foster care. Accompanying the deaths were allegations of negligence as a contributing factor and evidence of sexual and physical abuse, sometimes after clear warning signs.

Our objective was to determine whether the California Department of Social Services (Social Services), Community Care Licensing Division (licensing division), ensured that allegations and referrals of abuse and neglect of children eligible for foster care payments under Title IV-E of the Social Security Act, as amended (P.L. No. 74-271, Aug. 14, 1935), were recorded, investigated, and resolved in accordance with State requirements, as required by Federal law.

How OIG Did This Review

From the 6,182 priority I, II, and III complaint investigations that the licensing division completed from July 1, 2013, through June 30, 2015, we judgmentally selected 100 complaints against group homes or certified foster family homes in which a child eligible for Title IV-E foster care payments was involved. We reviewed the case files for the 100 complaints and, when necessary, interviewed licensing program analysts and supervisors.

California Did Not Always Ensure That Allegations and Referrals of Abuse and Neglect of Children Eligible for Title IV-E Foster Care Payments Were Properly Recorded, Investigated, and Resolved

What OIG Found

The licensing division did not (1) accurately record or investigate one complaint, (2) complete investigations in a timely manner, (3) refer priority I and II complaints (the most serious) to the Investigations Branch, (4) adequately cross-report complaints to the Children and Family Services Division and to law enforcement, (5) conduct onsite inspections within 10 days, (6) associate an employee of a community care facility with the facility, and (7) adequately clear plan-of-correction deficiencies.

The licensing division (1) lacked policies and procedures or did not follow existing policies and procedures and (2) did not require its analysts and supervisors to take periodic mandatory complaint investigation training. As a result, licensed facilities may be out of compliance with licensing laws or regulations, and children's health and safety may continue to be placed at risk.

What OIG Recommends and Social Services Comments

We recommend that the licensing division (1) develop an action plan to ensure that complaint investigations are completed in a timely manner; (2) develop additional policies and procedures as necessary and follow existing policies and procedures; (3) ensure that the new complaint system currently under development includes certain functionality; and (4) provide analysts and their supervisors periodic mandatory complaint investigation training to reinforce their knowledge of the laws, regulations, policies and procedures, and best practices related to complaint investigations.

Social Services agreed with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

The United States Senate Committee on Finance outlined concerns about the safety and well-being of children in foster care in an April 2015 letter addressed to State Governors and sought information about the States' use of private entities or organizations to administer some or all of their foster care programs. The letter describes the child welfare system as a "complex structure consisting of overlapping Federal, State, County and Tribal laws and practices carried out by a mix of public and private entities. At times, this structure leads to finger pointing and confusion when it comes to the question of who is responsible when something goes wrong." These issues were highlighted in a media report¹ that provided several examples of children who died while in foster care. Accompanying the deaths were allegations of negligence as a contributing factor and evidence of sexual and physical abuse, sometimes after clear warning signs, according to the article. To determine whether vulnerabilities in the complaint and investigation process exist, we are performing reviews of foster care agencies in several States, including California.²

OBJECTIVE

Our objective was to determine whether the California Department of Social Services (Social Services), Community Care Licensing Division (licensing division), ensured that allegations and referrals of abuse and neglect of children eligible for foster care payments under Title IV-E of the Social Security Act, as amended (P.L. No. 74-271, Aug. 14, 1935) (the Act), were recorded, investigated, and resolved in accordance with State requirements, as required by Federal law.

BACKGROUND

Federal Foster Care Program

Title IV-E of the Act established the Federal Foster Care Program, which helps States to provide safe and stable out-of-home care for children who meet certain eligibility requirements until they are safely returned home, placed permanently with adoptive families, or placed in other planned arrangements. At the Federal level, the Administration for Children and Families administers the program.

¹ *Mother Jones*, "The Brief Life and Private Death of Alexandria Hill." Available online at <http://www.motherjones.com/politics/2015/01/privatized-foster-care-mentor>. Accessed on April 10, 2017.

² Reports covering other States include *Ohio Ensured That Allegations and Referrals of Abuse and Neglect of Children Eligible for Title IV-E Foster Care Payments Were Recorded and Investigated in Accordance With State Requirements as Required by Federal Law* (A-05-16-00020), issued July 14, 2017, and *Texas Did Not Always Ensure That Allegations and Referrals of Abuse and Neglect of Children Eligible for Title IV-E Foster Care Payments Were Recorded and Investigated in Accordance With Federal and State Requirements* (A-06-15-00049), issued May 23, 2017.

A State must submit a State plan designating a State agency to administer the Federal Foster Care Program for the State (the Act § 471(a)(2)). The plan also provides, among other requirements, that the State agency report and provide information to an appropriate agency or official regarding known or suspected instances of physical or mental injury, sexual abuse or exploitation, or negligent treatment or maltreatment of a child receiving Foster Care Program aid (the Act §§ 471(a)(9)(A) and (B)). The plan further provides for the establishment or designation of a State authority or authorities that shall be responsible for establishing and maintaining standards for foster family homes and childcare institutions, including standards related to safety, and requires that the standards will be applied by the State to any foster family home or childcare institution receiving funds under sections IV-E or IV-B of the Act (the Act § 471(a)(10)).

Foster Care Program in California

In California, Social Services is the State agency that administers the Title IV-E program and is also responsible for protecting children in the Foster Care Program from abuse and neglect. Two of Social Services' divisions have lead roles: the Children and Family Services Division (family services division) and the licensing division.

Family Services Division

The family services division is responsible for overseeing the efforts of county child welfare services (CWS) agencies to protect children from abuse and neglect. CWS services range from those related to early intervention in the homes of abused and neglected children to those related to the permanent placement of such children.³ When CWS agencies determine that children's safety is at risk, they have the authority to remove the children from their homes and place them with relatives, foster parents, or group homes. Certain county placement agencies use licensed private foster family agencies as an alternative to group homes for placements of children who require more intensive care. Among the activities of a foster family agency are to recruit and train foster parents and to certify that a foster family home has met the State licensing requirements (certified family home).

Licensing Division

The licensing division oversees and regulates more than 73,400 licensed community-care facilities State-wide, including the licensing of foster family agencies and foster and group

³ We did not review the CWS agencies; however, the California State Auditor issued a series of reports on these agencies. The October 2011 report entitled *California Can and Must Provide Better Protection and Support for Abused and Neglected Children* included recommendations that Social Services (1) conduct regular address comparisons using the State of California Department of Justice's sex offender registry and its licensing database; (2) perform more timely comprehensive reviews of agencies' licensing activities as well as onsite reviews of State-licensed foster homes, foster family agencies, and group homes; and (3) require all county CWS agencies to perform child death reviews for children with CWS histories to improve their practices. <https://www.auditor.ca.gov/>. Accessed on April 10, 2017.

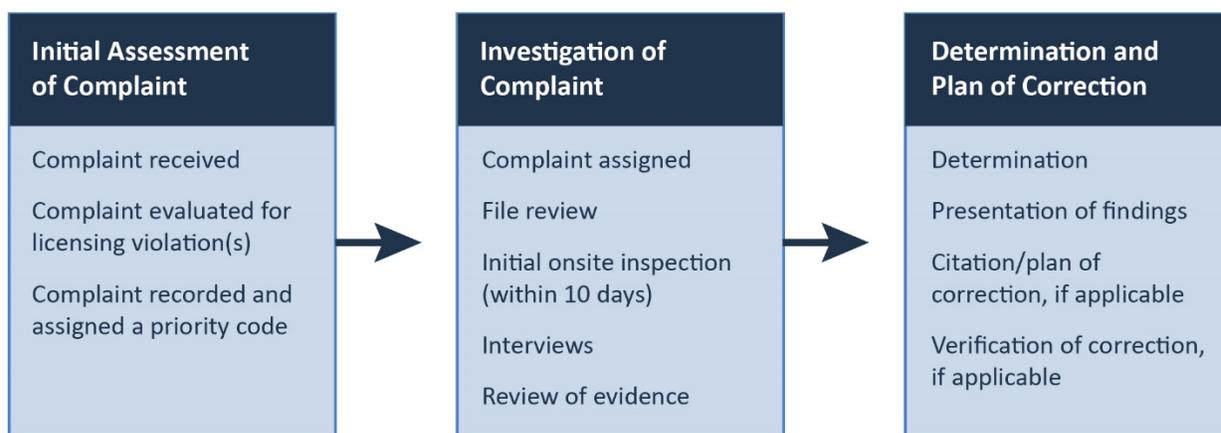
homes that house children removed from unsafe homes. The licensing division screens and inspects facilities, ensures that licensed facilities comply with applicable laws and regulations, and takes corrective action when facilities violate or cannot meet such laws and regulations. The licensing division operates out of five regions within the State.

California’s Complaint Investigation Process for Licensed Foster-Care Facilities

The licensing division investigates complaints made against licensed foster-care facilities to determine whether the facilities are in compliance with Federal and State laws and regulations. Licensing staff should follow the procedures and policies laid out in Social Services’ *Reference Material for Complaints* (Complaint Manual), which provides guidance on the complaint process.⁴

The complaint investigation process is shown in Figure 1.

Figure 1: Complaint Investigation Process in California



Initial Assessment of Complaint

According to licensing division officials, the investigative process generally starts when the licensing division receives an allegation of abuse, neglect, or noncompliance with health and safety standards at a licensed facility.⁵ The licensing program analyst who received the

⁴ The Complaint Manual, which is a section of Social Services’ *Evaluator Manual*, provides guidance on the complaint process but does not replace analyst judgment or management review. However, the licensing program analyst is still responsible for promptly initiating and following through on complaint investigations in the designated timeframes mandated by law and according to the procedures outlined in the Complaint Manual.

⁵ The allegation can come from a number of sources, including a referral from a different agency or department or from a child, parent, bystander, neighbor, teacher, facility employee, or police officer.

complaint determines whether a licensing law or regulation⁶ may have been violated. If a licensing law or regulation may have been violated, the analyst records the allegation and all applicable information in the licensing division's complaints Field Automation System (FAS).⁷ In the FAS, the analyst assigns to the complaint one of four priority codes, which identify the severity of the allegations. Priority I complaints are the most severe, while priority IV complaints are the least severe.

- **Priority I** complaints involve allegations such as sexual abuse with penetration of the genitals or physical abuse resulting in great bodily injury.
- **Priority II** complaints involve allegations such as sexual abuse that involve sexual behavior (without penetration) or physical abuse resulting in minor injuries or bruises.
- **Priority III** complaints involve allegations such as physical abuse with no injuries or bruises, or neglect or lack of supervision by a licensed facility, facility employee, volunteer, etc.
- **Priority IV** complaints involve allegations such as physical/corporal punishment (e.g., spanking or lack of supervision that did not result in any abuse or injury), unsanitary conditions, and other regulatory violations.

The analyst also assigns to each allegation 1 of 19 complaint codes to identify the type of allegation. These include codes for physical abuse/corporal punishment, sexual abuse, personal rights,⁸ and unlicensed care.

Investigation of Complaint

Once a complaint and all applicable information are recorded in the FAS, the complaint is assigned to one of the licensing division's five regions⁹ on the basis of the location of the facility and is then assigned to an analyst. The analyst reviews the complaint, and if it is coded as priority I or II, the analyst must refer the complaint to the Investigations Branch before initiating

⁶ All licensed community-care facilities regulated by the licensing division are subject to the Health and Safety Code and California Code of Regulations, Title 22.

⁷ According to licensing division officials, if an analyst determines that an alleged licensing violation did not occur, the licensing division does not have authority to investigate the complaint, and the analyst will either refer the reporting party or cross-report the complaint to an agency that has authority.

⁸ Examples of personal rights allegations are allegations that a child is (1) not living in a safe, healthy, and comfortable home; (2) not receiving adequate and healthy food and/or clothing; and (3) not receiving medical, dental, vision, and mental health services.

⁹ Each region has up to three suboffices.

a complaint investigation.¹⁰ According to a licensing division official, after discussing the complaint with the regional office, the Investigations Branch may choose to (1) accept the investigation and investigate the complaint in its entirety, (2) accept the investigation on assignment only and complete only specific tasks related to the investigation, or (3) reject the investigation on the basis of available resources and other factors and return it to the regional licensing office to investigate.

If the Investigations Branch does not accept the complaint or it is coded as priority III or IV, the analyst conducts a review of the files related to the facility's compliance and complaint histories, attempts to contact the person who filed the complaint to obtain any additional information, and plans the investigation. The analyst then performs an unannounced initial onsite inspection at the facility within 10 days of the receipt of the complaint. According to licensing division officials, for complaints against a certified family home, the analyst performs two initial onsite inspections, one at the foster family agency that certified the home and one at the certified family home itself. Both initial onsite inspections are required to be made within 10 days of the receipt of the complaint. During the onsite inspections, the analyst explains the purpose of the inspection to the facility representative and may review files, conduct interviews, and tour the facility.

During the investigation, the analyst attempts to interview as many witnesses related to the allegation as possible, including children who are the alleged victims. The analyst also gathers and reviews any relevant evidence, such as medical records, law enforcement reports, photographs, and fire inspection reports.

Complaint Determination and Plan of Correction

Once an investigation has been completed, the analyst makes a determination as to whether the allegation is:

- unfounded, indicating that the allegation is false, could not have happened, or is without a reasonable basis;
- inconclusive, indicating that although the allegation may have happened or is valid, there is not a preponderance of evidence to prove that the alleged abuse occurred; or
- substantiated, indicating that the allegation is valid because there is a preponderance of evidence to support that the alleged abuse occurred.

¹⁰ The Investigations Branch, which is within the licensing division, investigates higher priority complaints and completes specific investigative tasks (such as obtaining criminal record verification, police reports, and hospital records). Its investigators are peace officers who receive specialized training to better equip them to interview alleged victims and perpetrators on sensitive subjects.

The analyst then presents the findings to the facility. When an allegation is determined to be substantiated, the facility is cited, and appropriate administrative action is initiated. The analyst will then work with the facility to develop a plan of correction (POC). The POC details the criteria violated, corrective action that the licensee needs to take to be in compliance, and a due date for the corrections. The analyst is required to verify that the corrections have been made within 10 days of the due date. In addition, according to the licensing division's policy, complaint investigations should be completed in 90 days.

HOW WE CONDUCTED THIS REVIEW

From the 6,182 priority I, II, and III complaint investigations that the licensing division completed¹¹ from July 1, 2013, through June 30, 2015 (audit period), we judgmentally selected a total of 100 complaints against group homes or certified family homes in which a child eligible for Title IV-E foster care payments was involved. We based this selection on the consideration of certain risk factors, including but not limited to the severity of the complaint, the type of allegation, the number of days between the complaint receipt and investigation completion dates, and whether the complaint data indicated that the complaint had been cross-reported to other agencies and had been referred to the Investigations Branch.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains details of our audit scope and methodology. Appendix B shows the types of allegations and priority codes for the complaint investigations we reviewed.

FINDINGS

The licensing division did not always ensure that allegations and referrals of abuse and neglect of children eligible for foster care payments under Title IV-E of the Act were recorded, investigated, and resolved in accordance with State requirements. Specifically, the licensing division did not (1) accurately record or investigate one complaint, (2) complete investigations in a timely manner, (3) refer priority I and II complaints to the Investigations Branch, (4) adequately cross-report complaints to the family services division and to law enforcement, (5) conduct onsite inspections within 10 days, (6) associate an employee of a community care facility with the facility, and (7) adequately clear POC deficiencies.

¹¹ According to a licensing division official, a complaint investigation is considered complete once the supervisor reviews the analyst's work on the investigation and concurs with the determination made by the analyst. This approval may occur before the verification of the POC.

These findings occurred because the licensing division (1) lacked policies and procedures or did not follow existing policies and procedures and (2) did not require its analysts and supervisors to take periodic mandatory complaint investigation training. There were also limitations to the licensing division's complaint system. As a result of all these issues, licensed facilities may be out of compliance with licensing laws or regulations, and children's health and safety may continue to be placed at risk.

A COMPLAINT WAS NOT ACCURATELY RECORDED OR INVESTIGATED

For one complaint, the licensing division did not accurately record a priority II complaint alleging physical abuse/corporal punishment of a child and a personal rights violation against a certified family home. As a result, the licensing division did not investigate this complaint. The licensing division's policies and procedures require that recordkeeping and reports communicate information accurately, concisely, and completely and that these documents verify the analyst's accountability (*Reference Material for Office Functions* § 2-1000). Additionally, State law requires that Social Services complete all complaint investigations and place a note of final determination in the facility's file (Health and Safety Code § 1534.1(c)).

The complaint was opened against an incorrect foster family agency. The complaint should have been opened against the foster family agency that was responsible for the certified family home when the allegations occurred rather than when the complaint was reported. Because the licensing division lacked internal controls to record and investigate complaints when a complaint's facility information was incorrect and the complaint needed to be re-recorded, the complaint was not reopened under the appropriate foster family agency and thus was not investigated. This potentially placed at risk the health and safety of this child and any other children placed at this home. Once we informed the licensing division that the complaint had not been investigated, it opened a new complaint to initiate an investigation.

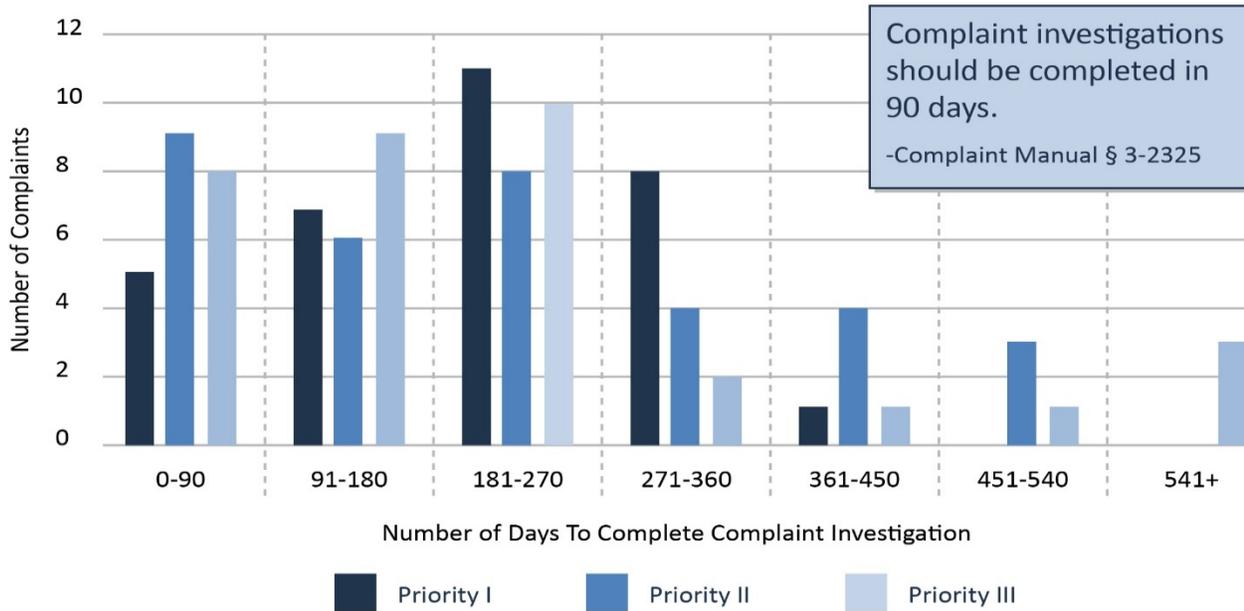
COMPLAINT INVESTIGATIONS WERE NOT COMPLETED IN A TIMELY MANNER

For 78 complaints, the licensing division did not complete the investigations in a timely manner. According to the licensing division's policy, complaint investigations should be completed in 90 days (Complaint Manual § 3-2325). Specifically, we found the following:

- For 22 complaints, the investigations took from 91 to 180 days to complete.
- For 43 complaints, the investigations took from 181 to 360 days to complete.
- For 13 complaints, the investigations took more than 360 days to complete.

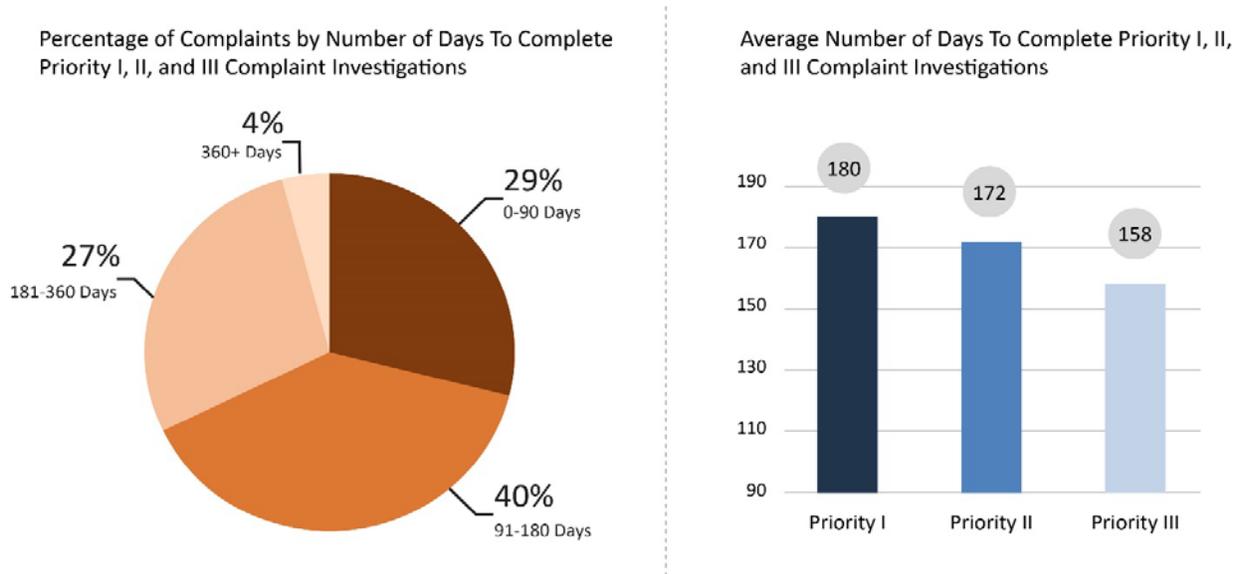
For 8 of these 78 complaints, it appeared that approximately 2 to 15 months passed in which no activities were noted to indicate that the complaints were being actively investigated. Figure 2 on the following page shows the number of days to complete the investigations for the 100 complaints we reviewed.

Figure 2: Length of Time To Complete Complaint Investigations



In addition, of the 6,182 priority I, II, and III complaint investigations completed during our audit period, 4,402 (or 71 percent) were not completed within the stated 90-day goal. On average, the 6,182 complaint investigations took over 161 days to be completed (Figure 3).

Figure 3: Percentage of Complaint Investigations Completed and Average Number of Days To Complete Investigations¹²



¹² From the data of completed complaint investigations we received from the licensing division for our audit period, we calculated the number of days to complete the investigation (using the complaint receipt and investigation completion dates) for each complaint, grouped the complaints by priority level, and then calculated the average number of days to complete an investigation for each priority level.

Licensing division officials stated that completing complaint investigations within 90 days is a goal, not a requirement. The licensing division has considered making it a requirement; however, officials stated that multiple factors may hinder a complaint investigation from being completed within 90 days, including finding the alleged victim, witnesses, and the alleged perpetrator to interview; coordinating and cooperating with law enforcement officials if they request that the licensing division hold off on initiating a complaint investigation; and obtaining police reports.

In fiscal year 2015, the licensing division had an average of 87 analysts working per month.¹³ These analysts investigated 4,409 received complaints and monitored 1,047 licensed group homes and 416 licensed foster family agencies.¹⁴ Additionally, a licensing division official stated that some complaint investigations may have periods of time in which it appears that work is not done because the analysts have many other job duties. For example, in addition to conducting investigations, the analysts are responsible for conducting prelicensing and annual/triennial reviews, making caseload management visits, preparing field reports, conducting group orientations for new licensees, and analyzing their own policies and procedures.

If the licensing division does not complete complaint investigations in a timely manner, the facilities may be out of compliance with licensing laws or regulations, which may continue to place children's health and safety at risk.

PRIORITY I AND II COMPLAINTS WERE NOT REFERRED TO THE INVESTIGATIONS BRANCH

For 10 complaints, the licensing division did not refer priority I and II complaints to the Investigations Branch.¹⁵ The licensing division's policies and procedures state that priority I and II complaints must be referred to the Investigations Branch before initiating any action on the complaint (Complaint Manual § 3-2010).

- For 8 of the 10 complaints, the licensing division was unable to provide documentation indicating that these complaints were referred to the Investigations Branch because the policies and procedures did not require retaining the referral documentation.¹⁶
- For one complaint, the analyst decided to investigate rather than refer the complaint to the Investigations Branch because she had a preexisting professional relationship with the child.

¹³ This figure does not include analysts who were on medical leave or other extended leave.

¹⁴ These 416 licensed foster family agencies certified and monitored 11,034 certified family homes.

¹⁵ Of the 100 complaints we reviewed, 32 complaints were priority I, and 34 complaints were priority II.

¹⁶ Because of the lack of documentation, we could not determine whether the Investigations Branch evaluated or investigated the complaints.

- For one complaint, the standard practice at one of the licensing division’s offices was not to refer complaints to the Investigations Branch if the allegation was against another child at the same facility.

Because Investigations Branch investigators receive specialized training on interviewing and conducting investigations of a more sensitive nature, they may be able to obtain more information regarding an allegation than an analyst can. Having an analyst instead of an investigator investigate a high-priority complaint could possibly lead to an incorrect determination on an allegation, which could place children’s health and safety at risk.

COMPLAINTS WERE NOT ADEQUATELY CROSS-REPORTED

For six complaints, the licensing division did not adequately cross-report complaints to either the family services division or law enforcement. Specifically, five of the complaints were not cross-reported to CWS, which is responsible for investigating alleged abuse and neglect of children, and one complaint was not cross-reported to law enforcement immediately or as soon as practicably possible.¹⁷

State law requires that when a mandated reporter¹⁸ receives information on a case of suspected child abuse or neglect, the agency that receives the report is required to cross-report it to the agency with proper jurisdiction immediately or as soon as practicably possible, with a written report to follow within 36 hours of receiving the information (Penal Code §§ 11165.9 and 11166(a)). Additionally, the licensing division’s policies and procedures indicate that whenever an analyst suspects abuse against a minor, the analyst should complete a “Suspected Child Abuse Report” form and submit it to law enforcement and Child Protective Services (Complaint Manual § 3-2110).

The licensing division failed to follow State law to adequately cross-report complaints to the appropriate agencies. If the licensing division does not adequately cross-report complaints, the family services division and law enforcement cannot adequately protect children.

ONSITE INSPECTIONS WERE NOT CONDUCTED OR WERE CONDUCTED LATE

For six complaints, the licensing division either did not conduct a required onsite inspection to initiate a complaint investigation or did not conduct onsite inspections within the required

¹⁷ The family services division oversees the county CWS departments that are responsible for investigating allegations of abuse and neglect of children. Those departments have the authority to move children if it is determined that their placement is unsafe. Law enforcement investigates allegations of abuse and neglect of children to determine whether a criminal act has taken place.

¹⁸ Examples of mandated reporters include teachers; licensing workers or licensing evaluators employed by a licensing agency; and employees of childcare institutions, including but not limited to foster parents, group home personnel, and personnel of residential care facilities (Penal Code § 11165.7(a)).

10-day period. After a complaint is received, State law requires that onsite inspections of community care facilities, including group homes and foster family agencies, or certified family homes be made within 10 days¹⁹ (Health and Safety Code § 1538(c)). In addition, according to licensing division officials, the practice was to perform onsite inspections of both foster family agencies and certified family homes within 10 days.

- For one complaint, which was priority I, the licensing division conducted the onsite inspection of the certified family home within 10 days but never conducted the onsite inspection of the foster family agency.
- For the remaining five complaints, consisting of two priority II complaints and three priority III complaints, the licensing division conducted the onsite inspections of the group home, certified family home, or foster family agency 2 to 15 days after the 10-day deadline. For two of these five complaints, the receipt dates listed in the complaint documents were inaccurate. The complaints were received 4 to 5 days before they were recorded in the FAS. As a result, the FAS showed that the onsite inspections were due later than if the actual received dates had been used.

According to a licensing division official, an analyst might perform a complaint inspection after the 10-day deadline because the analyst might be on vacation, and the supervisor might not reassign the complaint to another analyst. Additionally, for complaints made against certified family homes, the FAS is not designed to track onsite inspections of both the certified family home and the foster family agency. As long as the analyst completes the onsite inspection of either the certified family home or the foster family agency, the FAS will not alert the analyst that he or she has not visited both. Furthermore, when a complaint is opened in the FAS, the date and time of the complaint is automatically recorded as the receipt date, and the analyst cannot backdate the complaint to show the actual receipt date. The licensing division official informed us that Social Services is building a new complaint system that will integrate the systems used by the family services and licensing divisions.

If onsite complaint inspections are not conducted or are conducted late, completion of the complaint investigations is delayed, potentially placing children's health and safety at risk.

AN EMPLOYEE OF A COMMUNITY CARE FACILITY WAS NOT ASSOCIATED WITH THE FACILITY

For one complaint, the licensing division did not associate an employee of a community care facility with the facility at which he worked; that employee was accused of using an inappropriate restraint on a child residing at the facility. Before working at a licensed facility, an employee must obtain a criminal record clearance and, once cleared, the employee is associated with (or linked to) that facility. According to State law, all individuals are required to

¹⁹ Onsite inspections must be made within 10 days unless Social Services determines that the complaint is intended to harass, is without reasonable basis, or would adversely affect the licensing investigation or the investigation of other agencies (Health and Safety Code § 1538(c)).

obtain either a criminal record clearance or a criminal record exemption from Social Services before being in a community care facility or certified family home (Health and Safety Code § 1522). Additionally, each individual required to obtain a criminal record clearance must request a transfer of the clearance to a different licensed facility before working, residing, or volunteering there (California Code of Regulations § 80019(e)(2)). One of the licensing office's general practices was not to require that an employee be associated with the specific facility at which he or she worked as long as the employee was associated with another facility within the same chain.

If an employee is not associated with the facility at which he or she is working and is subsequently no longer allowed to work at licensed community-care facilities, the licensing division will be unable to contact the facility and inform the facility that the individual is no longer allowed to work there. This potentially places children's health and safety at risk.

PLAN-OF-CORRECTION DEFICIENCIES WERE NOT ADEQUATELY CLEARED

For five complaints, the licensing division did not adequately clear POC deficiencies:

- For three complaints, the deficiencies were not cleared.
- For two complaints, the deficiencies were not cleared for 1 and 1½ years after the due dates, respectively.²⁰

Licensing division policies and procedures require that each time a citation is issued, a POC due date be established; those policies and procedures further require that a followup visit be conducted to verify the corrections within 10 working days of the due date unless other approved means are used to clear the deficiencies (*Enforcement Actions Manual* § 1-0060). A licensing division official stated that because the FAS does not have an indicator or alert to help track when the POC deficiencies need to be cleared, the analysts must remember to clear them. However, because the analysts have many other job functions, they may not clear them as required.

If analysts do not clear POC deficiencies or do not clear them in a timely manner, the licensing division has no assurance that facilities corrected the deficiencies and that violations leading to the allegations were adequately resolved. This potentially places children's health and safety at further risk.

²⁰ For these five complaints, the plans of correction involved ensuring that training was provided to group home staff, foster family agency staff, or certified foster parents. Examples of training included complying with reporting requirements, recognizing staff responsibilities and boundaries, and respecting children's personal rights.

RECOMMENDATIONS

We recommend that the licensing division:

- develop an action plan to ensure that complaint investigations are completed in a timely manner;
- develop policies and procedures to (1) ensure that all complaints are recorded and investigated (specifically, when a complaint's facility information is incorrect and the complaint needs to be re-recorded), (2) retain Investigations Branch referral documentation, and (3) record complaints immediately after they are received;
- follow existing policies and procedures to (1) refer all priority I and II complaints to the Investigations Branch, (2) adequately cross-report complaints, (3) conduct onsite complaint inspections within the required 10-day timeframe, and (4) clear POC deficiencies in a timely manner;
- ensure that the new complaint system includes functionality to (1) create alerts to track 10-day inspections of both foster family agencies and certified family homes and to ensure clearance of POC deficiencies, (2) allow analysts or supervisors to enter or revise complaint receipt dates, and (3) indicate when a referral to the Investigations Branch has been made; and
- provide analysts and their supervisors periodic mandatory complaint investigation training to reinforce their knowledge of the laws, regulations, policies and procedures, and best practices related to complaint investigations.

DEPARTMENT OF SOCIAL SERVICES COMMENTS

In written comments on our draft report, Social Services agreed with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations. Social Services' comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From the 6,182 priority I, II, and III complaint investigations²¹ that the licensing division completed from July 1, 2013, through June 30, 2015, we judgmentally selected a total of 100 complaints against group homes or certified family homes (20 from each of the licensing division's 5 regions) in which a child eligible for Title IV-E foster care payments was involved. We based this selection on the consideration of certain risk factors, including but not limited to the severity of the complaint, the type of allegation, the number of days between the complaint receipt and completion dates, and whether the complaint data indicated that the complaint had been cross-reported to other agencies and had been referred to the Investigations Branch.

Our review enabled us to establish reasonable assurance of the reliability of the data obtained from the FAS; however, we did not assess the completeness of the data. In addition, we did not assess Social Services' overall internal control structure. Rather, we limited our review of internal controls to those applicable to our audit objective.

We conducted site visits from April 4 to May 13, 2016, at the licensing division's regional offices located in Sacramento, San Jose, Monterey Park, Culver City, and Riverside, California. We also performed fieldwork in February and August 2016 at Social Services' offices in Sacramento, California.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal laws and State laws, regulations, and policies related to recording, investigating, and resolving allegations and referrals of abuse and neglect of children in foster care;
- interviewed Social Services officials and licensing division officials, supervisors, and analysts to determine the licensing division's investigative process for complaints;
- obtained data from the licensing division for all completed complaint investigations for the audit period;
- judgmentally selected for review 100 complaints (coded as priority I, II, and III) against group homes or certified family homes (20 from each of the licensing division's 5 regions);

²¹ These complaints were obtained from the FAS. We did not perform a review to ensure that all complaints were recorded.

- reviewed the case files for the 100 complaints and, when necessary, interviewed analysts and supervisors to determine whether the complaints were recorded, investigated, and resolved in accordance with State requirements; and
- discussed the results of our review with Social Services and licensing division officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

**APPENDIX B: TYPES OF ALLEGATIONS AND PRIORITY CODES
FOR COMPLAINT INVESTIGATIONS REVIEWED**

Table: Types of Allegations and Priority Codes

Type of Allegation	Priority I	Priority II	Priority III	Total
Physical abuse/corporal punishment	3	15	4	22
Sexual abuse	17	7	3	27
Personal rights	7	15	21	43
Neglect/lack of supervision	17	12	43	72
Other ²²	9	4	10	23
Total	53	53	81	187*

Note: Forty-eight complaints had multiple allegations. For each complaint with multiple allegations, we categorized all the allegations under the highest priority code for that complaint.

²² Examples of allegations included in this category are those related to medication, recordkeeping, and food service.

APPENDIX C: DEPARTMENT OF SOCIAL SERVICES COMMENTS



CDSS
WILL LIGHTBOURNE
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • www.cdss.ca.gov



EDMUND G. BROWN JR.
GOVERNOR

August 21, 2017

Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

Dear Ms. Ahlstrand:

SUBJECT: CALIFORNIA DID NOT ALWAYS ENSURE THAT ALLEGATIONS AND
REFERRALS OF ABUSE AND NEGLECT OF TITLE IV-E FOSTER CARE
CHILDREN WERE PROPERLY RECORDED, INVESTIGATED, AND
RESOLVED A-09-16-01000

This letter provides the California Department of Social Services' (CDSS) initial response to the Department of Health and Human Services Office of Inspector General draft of the above entitled report.

If you have any questions concerning the enclosed CDSS response, please contact me at (916) 657-2598 or Cynthia Fair, Audits Bureau Chief, at (916) 651-9923.

Sincerely,

WILL LIGHTBOURNE
Director

Enclosure

California Department of Social Services (CDSS)
RESPONSES TO AUDIT RECOMMENDATIONS

Department of Health and Human Services Office of Inspector General

Audit #: A-09-16-01000

Audit Title: ***California Did Not Always Ensure That Allegations And Referrals Of Abuse And Neglect Of Title IV-E Foster Care Children Where Properly Recorded, Investigated, And Resolved***

Recommendations for Social Services:

Recommendation 1:

We recommend that the licensing division develop an action plan that complaint investigations are completed in a timely manner.

CDSS Initial Response:

Fully Implemented/Date Implemented: December 2016. CDSS agrees with this recommendation and has developed an action plan to address complaints being investigated in a timely manner. CDSS created an action plan that included the development of dashboards for managers to track the status of complaints, retired annuitants were hired to support targeted areas that needed assistance with complaint investigations or investigating complaints, complaint teams were initiated, and monthly meetings with managers are being held with Licensing Program Analysts (LPAs) to track the timeliness of investigations.

Recommendation 2:

We recommend that the licensing division develop policies and procedures to (1) ensure that all complaints are recorded and investigated (specifically, when a complaint's facility information is incorrect and the complaint needs to be re-recorded), (2) retain Investigations Branch referral documentation, and (3) record complaints immediately after they are received.

CDSS Initial Response:

Fully Implemented/Date Implemented: April 2017. CDSS agrees with this recommendation and on April 21, 2017 issued a Regional Office Memo (ROM) (Attachment A) reminding staff that in the event a complaint is written up against the wrong facility, it is the responsibility of the LPA and Licensing Program Manager to ensure that the complaint is recorded correctly within the next working day. The ROM also reminds staff that the due date of the initial complaint inspection should be recorded as the 10th calendar day from the date CDSS receives the complaint. Data

reported January through June of 2017 shows 99.4 percent inspections were initiated within the 10-day timeframe.

Additionally, in a Regional Manager's meeting in December 2016, expectations were communicated that the regional offices shall retain Investigations Branch referral documentation and all Regional Managers confirmed that this documentation will be retained.

Recommendation 3:

We recommend that the licensing division follow existing policies and procedures to (1) refer all priority I and II complaints to the Investigations Branch, (2) adequately cross-report complaints, (3) conduct onsite complaint inspections within the required 10-day timeframe, and (4) clear plan of correction (POC) deficiencies in a timely manner.

CDSS Initial Response:

Fully Implemented/Date Implemented: April 2017. CDSS agrees with this recommendation. On October 1, 2016 CDSS implemented a new triage process where all Priority I and II complaints must be triaged through either the Northern or Southern Investigations Branch Office for standardization and tracking purposes. Additionally, on April 21, 2017, CDSS issued a ROM (Attachment A) reminding staff that Priority I and II complaints must be referred to the Investigations Branch and cross-reported to law enforcement and county protective service agencies. The ROM also addresses the requirement that an on-site facility visit must be made within ten calendar days of a complaint and that plan of correction deficiencies must be cleared in a timely manner and documented in the file. For quality assurance, files are randomly pulled to ensure staff are adhering to these expectations.

Recommendation 4:

We recommend that the licensing division ensure that the new complaint system includes functionality to (1) create alerts to track 10-day inspections of both foster family agencies and certified family homes and to ensure clearance of POC deficiencies, (2) allow analysts or supervisors to enter or revise complaint receipt dates, and (3) indicate when a referral to the Investigations Branch has been made.

CDSS Initial Response:

Partially Implemented/Anticipated Implementation Date: Early 2019. CDSS agrees with this recommendation. The Certification and Licensing System (CALs) is currently being built as a module of the new Child Welfare System-New System. CDSS has included the functionality identified in this recommendation. There will be functionality to generate alerts for 10-day inspections of both foster family agencies and certified family homes/resource family homes and to clear plans of corrections. CALs will also include the recording of complaints received, and allow analysts or supervisors to enter or

revise complaint receipt dates. Dates of Investigations Branch referrals will also be included in CALS.

Recommendation 5:

We recommend that the licensing division provide analysts and their supervisors periodic mandatory complaint investigation training to reinforce their knowledge of the laws, regulations, policies and procedures, and best practices related to complaint investigations.

CDSS Initial Response:

Partially Implemented/Anticipated Implementation Date: February 2018. CDSS agrees with this recommendation. In 2015, the Community Care Licensing Division, Children's Residential Program (CRP) required all regional office licensing staff to attend training on the complaint investigations process. Currently, the training materials as well as the overall investigations process are being updated for the Community Care Licensing Program to employ more effective, and standardized investigation and documentation principles. The CRP plans to implement the updated process and require training of all its regional office licensing staff by 2nd quarter 2018.



STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
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Attachment A



EDMUND G. BROWN JR.
GOVERNOR

April 21, 2017

ROM 17-01-CRP

TO: All Children's Residential Program Staff
Original signed by Pamela Dickfoss
FROM: PAMELA DICKFOSS
Deputy Director
Community Care Licensing Division
SUBJECT: REFERENCE MATERIAL IN EVALUATOR MANUAL

Regional Office Memo (ROM) Summary

The purpose of this ROM is to improve data entry and investigative timeframes for Priority I and II complaints.

As a reminder, the Evaluator Manual (EM) is a self-contained handbook for licensing staff for the application and enforcement of laws, regulations, policies and procedures. To ensure statewide consistency in the administration of the licensing program, it is important to utilize this reference source.

Inaccurate Information in a Complaint

In the event that a Licensing Program Analyst (LPA) finds inaccurate information such as a complaint written under a wrong facility, it is the responsibility of the LPA and Licensing Program Manager (LPM) to immediately correct the information and/or return the complaint to the Centralized Complaint and Information Bureau (CCIB) to fix. However, it is still the responsibility of the LPA/LPM to follow up and ensure that the mistakes are corrected within the Field Automation System (FAS) within the next working day.

IB Referrals

Per EM 3-2010, the general statement clearly states that upon receiving allegations involving priority I or II complaints, the complaint must be referred to the Investigations Branch (IB). Recently it was discovered that there were instances where these complaints were not referred to IB, or lacked documentation when they were referred. The LPA's are responsible for referring allegations involving priority I or II situations to IB prior to initiating any action on a complaint. In addition, the LPA must comply with specific reporting responsibilities when a complaint is received. Priority I or II complaints

must be reported to police departments, sheriff departments, probation departments, and county protective service agencies.

Timeframes and Documenting an Investigation

Per EM 3-2120, an on-site facility visit must be made within ten calendar days of a complaint. It is important that all LPAs document all activity related to the investigation in FAS when responding to complaints and to follow through on complaint investigations in the designated time frames mandated by law and the procedures outlined in the EM. A way to ensure that the timetables are met is to check the Workflow in FAS along with emails on a daily basis.

In the event that a complaint is received on a Friday but not written up until Monday which causes an incorrect due date in FAS, we suggest that the LPA retrograde the due date to ensure that it reflects an accurate due date. For example, if a complaint is received on Friday, March 17th and not entered into FAS until Monday, March 20th, the ten days begins on Saturday, March 18th. So the accurate due date will be Monday, March 27th, and should be changed to reflect that date in FAS.

Clearing Complaints

Per EM 3-2400, after the investigation is completed and the LPA has delivered the findings to the licensee, including citations and plans of correction, the LPA must indicate the resolution for each allegation and complete the LIC 802 and submit to their manager within FAS. It is the responsibility of the LPM to review and approve the complaint investigation and findings and the LPA is responsible for timely follow up to ensure the facility has completed their plans of correction. LPAs are to clear the plan of correction in FAS and make a copy of the plan of correction letter for the licensee.

Multiple Facility Licensees

Per EM 7-1100, licensees with multiple licensed facilities have the option to designate one facility, within a regional office, as the central administrative facility to which all record background checks may be associated. A licensee may request a waiver which must be approved before they're allowed to designate one facility as the central administrative facility to which all criminal record background checks are associated. If the licensee waiver is not approved and an employee is working at a facility that they are not associated to, the LPA must cite the licensee, assess civil penalties, and give the facility administrator a Criminal Background Check Transfer Request form (LIC 9182) to complete during the visit.

If you have any questions, please contact Jean Chen, Assistant Program Administrator at (916) 651-5380.